UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
SOUTHEASTERN DIVISION

GARY M. ASBERRY,	)	
	)	
Plaintiff,	)	
	)	
v.	)	No. 1:01 CV 96 CEJ DDN
	)	
JO ANNE B. BARNHART, Commissioner of Social Security,	)	
	)	
Defendant.	)	

REPORT AND RECOMMENDATION
OF UNITED STATES MAGISTRATE JUDGE

This action is before the court for judicial review of the final decision of the defendant Commissioner of Social Security denying plaintiff's applications for disability insurance benefits under Title II of the Social Security Act (the Act), 42 U.S.C. §§ 401, et seq., and for supplemental security income benefits based on disability under Title XVI of the Act, 42 U.S.C. §§ 1381, et seq. The court has subject matter jurisdiction over the action under 42 U.S.C. §§ 405(g) and 1383(c)(3). The action was referred to the undersigned United States Magistrate Judge for a recommended disposition under 28 U.S.C. § 636(b).

Plaintiff Gary M. Asberry filed his current applications for benefits on November 15, 1996, at age 44. He alleged he became disabled on February 28, 1996, because of shoulder pain, dizziness, and heart problems. (Tr. 135). His past employment was as a pallet nailer, a forklift truck driver, and a lead company laborer. (Tr. 68).

The administrative record

On July 7, 1994, plaintiff was examined by James E. Palen, M.D., on referral by plaintiff's counsel. Plaintiff gave Dr. Palen a history of left elbow pain beginning in October 1992. Plaintiff

had been employed at a pallet recycling company where he operated a nailer hand gun. This required him to lift pallets off a conveyor belt approximately 1,000 to 1,400 times in an eight-hour shift. Dr. Palen found that plaintiff had continuous pain in his left shoulder and left elbow, and complained of numbness and tingling in both arms, especially in the morning. Plaintiff said he was unable to drive due to the discomfort in his arm, open a jar at home, or do yard work which required him gripping with his hand. Dr. Palen performed a physical examination and found that plaintiff had decreased strength in the left hand grip and the left forearm. Dr. Palen diagnosed chronic tendinitis in the left elbow, and assigned a permanent partial disability rating of 30 percent of the left upper extremity. (Tr. 160-61).

On February 23, March 2, December 14, and December 28, 1995, plaintiff was treated by Suwan Phanijphand, M.D. Plaintiff complained of dizziness and a ringing in his ears. He was prescribed a CT scan of his ear canal, a low salt diet, and medication. A CT scan on March 2 was normal. (Tr. 294-95).

Between July 18, 1994, and October 29, 1996, Dorothy M. Munch, D.O., treated plaintiff for various medical problems. On July 18, 1994, plaintiff complained of left shoulder pain since 1993. On October 17, 1994, he complained of his left arm going numb and his shoulder areas hurting with a full range of motion. Dr. Munch diagnosed persistent bi-lateral shoulder pain and left arm tenderness. (Tr. 196). On December 12, 1994, and January 3, 1995, Dr. Munch again noted shoulder pain. On January 3, 1995, she noted plaintiff's complaints of dizziness. (Tr. 195). On February 16, 1995, Dr. Munch assessed tinnitus and shoulder pain. (Tr. 194). On May 18, 1995, Dr. Munch noted complaints that his shoulders were not any better. On June 9 and September 28, 1995, and May 14 and July 15, 1996, plaintiff complained of dizziness. (Tr. 193). Plaintiff stated to Dr. Munch that the dizziness usually occurs when he is sitting or standing still, but it improves with walking. Dr. Munch diagnosed probable peripheral vertigo. (Tr. 189).

On December 11, 1995, July 23, September 17, and November 11, 1996, plaintiff was examined by Bob R. Carnett, D.O., for complaints of left shoulder discomfort and numbness. Dr. Carnett prescribed medication. (Tr. 182-85).

On April 18 and 19, 1996, plaintiff was hospitalized for chest pain. He underwent cardiac catherization and related examination. Ronald A. Weiss, M.D., treated him and diagnosed coronary artery disease, hyperlipidemia and status post PTCA of two lesions in mid LAD. Dr. Weiss noted that the cardiac catherization performed on April 18 revealed an 85 percent mid-1 LAD stenosis and 80 percent mid-2 LAD stenosis. Both of these conditions were successfully dilated to a minimal residual. Medication was prescribed and a follow-up treadmill test. (Tr. 241-92).

On June 14, 1996, Dr. Weiss performed a treadmill test on plaintiff. The doctor found borderline ischemia, appropriate heart rate and blood pressure response to exercise, no arrhythmia, no chest discomfort with exertion and exercise tolerance. (Tr. 240).

On September 24, 1996, plaintiff was examined by Dr. Weiss for some left side chest discomfort unrelated to exertion. It increased with palpation and is associated with emotional excitement. Plaintiff noted some relief with nitroglycerin. Dr. Weiss diagnosed known coronary artery disease, status post previous PTCA of two lesions in the LAD, chest discomfort consistent with costochondritis and a history of hyperlipidemia. (Tr. 236).

On October 11, 1996, Dr. Weiss administered a stress test to plaintiff. The results were borderline abnormal stress test, appropriate heart rate response to exercise, mildly hypertensive blood pressure response to exercise, rare PVCs seen during exercise, and good exercise tolerance. (Tr. 200).

On December 3, 1996, plaintiff underwent an eye examination by Dennis White, O.D. Dr. White indicated that plaintiff's best correction of both eyes was 20/20-1. (Tr. 179-80).

On December 17, 1996, plaintiff was examined by H.K. Varma, M.D., at the request of the state agency. Plaintiff complained of

pain in both arms, both knees, and his lower back. Plaintiff also complained of dizziness for the past two years. Dr. Varma noted that, three or four times a week, plaintiff experiences sharp chest pain that radiates down the left arm up to the elbow and lasts for about 15-20 minutes. This pain is relieved by nitroglycerin. Dr. Varma's impression was difuse musculoskeletal pain involving both upper extremities, both knees, both hips, and the lower back, the cause of the pain being undetermined. Dr. Varma stated that plaintiff's ability to perform work-related activities could not be evaluated without an EKG and chest X-ray. (Tr. 170-73).

On December 17, 1996, Thomas H. Carter, Ph.D., administered a psychological examination of plaintiff for the state agency. Dr. Carter noted that plaintiff appeared to be an intense, worried and mildly anxious person. Plaintiff seemed to worry about his health and his finances. Dr. Carter noted that plaintiff had a slight impairment in his concentration and his attention span when he is in pain. Further, the doctor noted that plaintiff's concentration and task persistence were at the low average level. Dr. Carter's assessment was that plaintiff had the ability to understand and remember simple and relatively complex oral and written instructions, to sustain concentration and task persistence with simple and relatively complex tasks. In addition, the doctor noted that plaintiff had adequate social skills, but that his ability to concentrate seemed mildly impaired at times, probably due to the stress of coping with his Worker's Compensation suit and worries about finances and his health. The doctor noted that plaintiff appeared to suffer from mild anxiety and bouts of mild to moderate depression. Dr. Carter diagnosed mild to moderate mood disorder that was produced by health and financial problems. He gave plaintiff a Global Assessment of Functioning of 63. (Tr. 163-69).

At the evidentiary hearing before the ALJ, plaintiff testified that he is able to drive a car around town, but not long distances because his arms and legs go to sleep and it makes him extremely

nervous. (Tr. 329). Plaintiff graduated from high school, has one year of college, and can read and write. (Tr. 329).

Plaintiff last worked in October 1992, until he was injured working at a mill. Then he was using his left arm to pull pallets which required a repetitive motion that injured his left arm. (Tr. 330). He has been treated by Jose Hernandez, a psychiatrist, for nerves and stress arising from his Workmen's Compensation claim and his Social Security claim. Dr. Hernandez prescribed Valium and Prozac for plaintiff. (Tr. 332).

Plaintiff testified that he had undergone an angioplasty approximately two years before the Social Security hearing. (Tr. 332). He also had his right knee operated on. He experiences dizziness which worsens with his current medication. (Tr. 333).

Plaintiff testified that he could use his left arm to lift no more than 10 pounds. His elbow condition has remained as it was after he injured it in October 1992.

Plaintiff testified that he experiences worsening dizziness every day, twice a day. He testified that he can be going down the street taking his boy to school and end up at a stop sign and not really know where he is at. He testified that when he gets dizzy he can hardly walk, he stumbles, and he does not have any balance. (Tr. 337).

Plaintiff testified that he experiences problems with his heart, that he takes a nitroglycerine pill once every two days because of chest pain. (Tr. 338-39).

Plaintiff testified that he can walk on his knee fine, but he is not able to jump off anything. (Tr. 340).

He testified that if he sits in a certain position in his car, his legs will go to sleep. He could walk a half mile without having problems or difficulties. Plaintiff testified that he could sit for up to 30 minutes at a time, after which he has to rise and walk around. (Tr. 342A). He does not have strength in his right and left hands. (Tr. 342-43).

Plaintiff testified that he can lift and carry from one room to another about four pounds and he gave an example of lifting a sack of flour or a sack of sugar. He could drag along a gallon of milk. (Tr. 343). He has trouble bending to enter a car. He tries not to sit around and think about his Workmen's Compensation and Social Security Disability claims. He does not do yard work; his son does it. Plaintiff testified that he does not do any house cleaning, except picking up the end of his table. Plaintiff testified that on his good days he can run a vacuum cleaner and change sheets, but on a bad day he could not. (Tr. 344-45).

Plaintiff testified that he has problems with his memory and concentration. He could read something, lay it down and not remember it. He further explained that his wife may tell him something, but he will not remember it the next day. (Tr. 346).

Plaintiff testified that after he underwent the angioplasty he was walking and jogging two miles for his cardiologist. However, his knees began giving him problems, so he quit jogging. (Tr. 349-50).

Plaintiff testified that he goes to the shooting range about once every month, which is less than he used to do. Even though turkey season was coming up, he was not sure he could participate, because of the gun recoil. He last went hunting in October or November. At that time, he did not shoot, because he did not feel like doing it. (Tr. 351). Nevertheless, he spends some time outdoors letting his dog run and picking up sticks in the yard. (Tr. 352).

The Commissioner's decision

On April 17, 1998, an evidentiary hearing was held before an Administrative Law Judge (ALJ). The ALJ issued his written opinion on November 16, 1998. In that opinion, he made the following findings of fact and conclusions of law that are at issue in this action:

1. Plaintiff met the disability insured status required by Title II of the Act only through December 31, 1997.

2. Plaintiff has not worked since October 1992.

3. Plaintiff suffers from a history of left elbow surgery, a history of hyperlipidemia, status post PTCA, dizziness, and diffuse musculo-skeletal pain in his limbs. These impairments are severe.

4. Plaintiff does not suffer from an impairment or combination of impairments listed, or medically equal to one listed, in the Commissioner's list of disabling impairments. Further, he has no significant non-exertional limitation which narrows the range of work he is able to perform.

5. Plaintiff's allegations about his impairments and their impact on his ability to work are not entirely credible.

6. Plaintiff has the residual functional capacity to occasionally lift and carry ten pounds, to use his arms and hands to manipulate and handle objects, and to sit for six hours in an eight hour day.

7. Plaintiff cannot perform his past relevant work as a pallet maker and as a laborer.

8. Under the Commissioner's regulations, plaintiff is a "younger" person; he has a high school education.

9. Under Commissioner's Medical-Vocational Guidelines (Grid) Rules 201.21 and 201.28, administrative notice is taken of the fact that there are a significant number of jobs in the national economy that plaintiff can perform.

10. In consequence, plaintiff is not disabled under the Act.

(Tr. 18-19).

DISCUSSION

In this judicial review of the Commissioner's final decision, the court

> must determine whether the Commissioner's findings are supported by substantial evidence on the record as a whole. See Prosch v. Apfel, 201 F.3d 1010, 1012 (8th Cir. 2000). "Substantial evidence is less than a preponderance, but is enough that a reasonable mind would

> find it adequate to support the Commissioner's conclusions." Id. The court may not reverse merely because evidence would have supported a contrary outcome. See id.

Dunahoo v. Apfel, 241 F.3d 1033, 1037 (8th Cir. 2001).

In determining whether the Commissioner's findings are supported by substantial evidence, the court must consider "evidence that detracts from the Commissioner's decision as well as evidence that supports it." Warburton v. Apfel, 188 F.3d 1047, 1050 (8th Cir. 1999).

Under the Act, plaintiff must prove that he is unable to perform any substantial gainful activity due to any medically determinable physical or mental impairment which would either result in death or which has lasted or could be expected to last a continuous period of at least 12 months. See 42 U.S.C. §§ 423(a), 1382c(a)(3)(A).

Under the Commissioner's regulations, plaintiff must first prove that one or more impairments prevent him from performing his past relevant work. Pickner v. Sullivan, 985 F.2d 401, 403 (8th Cir. 1993). If he satisfies this burden, the burden shifts to the Commissioner to prove that he is able to perform some other substantial gainful activity in the national economy, given his residual functional capacity, his age, education, and work experience. Id. As set forth above, the ALJ concluded that plaintiff sustained this burden and the ALJ acknowledged that the burden shifted. (Tr. 16).

In this action, plaintiff argues (1) the ALJ failed to specifically identify the evidence which supported his findings of plaintiff's residual functional capacity; and (2) the ALJ failed to properly determine the credibility of plaintiff's subjective complaints and testimony. Defendant argues that the decision of the Commissioner is supported by substantial evidence and must be affirmed.

Under the regulations, the Commissioner must engage in a five-step analysis of the record. This analysis covers consideration of any current work activity, the severity of the plaintiff's impairments, his residual functional capacity and age, education, and work experience. 20 C.F.R. § 404.1520(a); Braswell v. Heckler, 733 F.2d 531, 533 (8th Cir. 1984). In this case, the ALJ reached step five and determined that the regulations indicated that there were jobs available for plaintiff and that he was not disabled. On the record as a whole, the denial of benefits is supported by substantial evidence.

In finding that plaintiff had the residual functional capacity to do other kinds of work and that other work plaintiff could do existed in substantial numbers in the national economy, the Commissioner relied on the Medical-Vocational Guideline rules[1] to take administrative notice of these facts.

Generally, when a decision cannot be made on the medical considerations alone, a disability claimant can properly be evaluated under the Medical-Vocational Guidelines, which take administrative notice of whether a significant number of jobs exist in the national economy for a person with a certain residual functional capacity, age, education, and work experience. Heckler v. Campbell, 461 U.S. 458, 462 (1983). Proper reliance on the Grid eliminates the need for the Commissioner to consider and rely upon the testimony of a vocational expert. McCoy v. Schweiker, 683 F.2d 1138, 1148 (8th Cir. 1982) (en banc). And, when the Grid is properly relied upon, it is unnecessary for the Commissioner to identify specific jobs in the economy that plaintiff can perform, as plaintiff argues. Heckler, 461 U.S. at 467-68.

The law is clear, however, that the Grid may not be used in the case of a claimant who suffers from one or more non-exertional limitations, such as pain. Simons v. Sullivan, 915 F.2d 1223, 1225 (8th Cir. 1990). In such cases, the Commissioner must usually

[1]See 20 C.F.R. Part 404, Subpart P, Appendix 2.

consider the testimony of a vocational expert. Muncy v. Apfel, 247 F.3d 728, 735 (8th Cir. 2001).

Plaintiff argues, first, that the ALJ did not properly assess his credibility. The ALJ's determination, however, is consistent with the standards set forth in Polaski v. Heckler, 739 F.2d 1320, 1321-22 (8th Cir. 1984), and the regulations. See 20 C.F.R. §§ 404.1529, 416.929 (2001). The ALJ noted that plaintiff's own testimony described substantial physical activities, including driving short distances (Tr. 329), walking and jogging two miles a day in December 1996 which he alleged that he stopped due to knee problems (Tr. 349), deer hunting in November 1996 and 1997 (Tr. 351), and going to the shooting range twice a week in December 1996 (Tr. 165, 350-51).

In addition, plaintiff reported to psychologist Carter in December 1996 that he visited his brother, attended his daughter's basketball games, and attended church weekly. (Tr. 13, 165). Although daily activities alone do not disprove disability, they may be considered when evaluating subjective complaints. See Wilson v. Chater, 76 F.3d 238, 241 (8th Cir. 1996).

Further, as the ALJ noted, plaintiff made inconsistent statements about his ability to perform physical activities. (Tr. 15). He testified at the hearing that he walked two miles a day after his heart surgery (Tr. 349), but told Dr. Carter that he was able to walk and jog three miles a day in December 1996 without chest pain (Tr. 165). During a thallium stress test in June 1996, plaintiff was able to walk for 12 minutes with no report of chest pain. (Tr. 240). At a subsequent test in October 1996, plaintiff reported no chest pain, and the test was terminated due to achievement of maximum heart rate, not due to fatigue or pain. (Tr. 200).

The ALJ also noted that the objective medical evidence did not support plaintiff's allegation that he had no strength in his hands and numbness in his extremities. (Tr. 15). Dr. Varma noted no motor or sensory deficits, and plaintiff's deep tendon reflexes

were normal. (Tr. 171-72). Although plaintiff testified that he had vision difficulties, the result of his visual acuity testing was 20/20-1. (Tr. 179-80).

Plaintiff's treating physician, Dr. Munch, stated that plaintiff could perform work-related activities, and completed a medical form so that plaintiff could renew his license as an EMT. (Tr. 15, 189). The failure of a treating physician to impose limitations is a lawful consideration when deciding disability vel non. Brown v. Chater, 87 F.3d 963, 965 (8th Cir. 1996).

Plaintiff argues that the ALJ's credibility determination was insufficient because he did not specifically discuss each of the factors set forth in Polaski v. Heckler. "Although the ALJ did not explicitly discuss each Polaski factor in a methodical fashion, he acknowledged and considered those factors before discounting [the plaintiff's] subjective complaints of pain." Brown v. Chater, 87 F.3d 963, 966 (8th Cir. 1996). Further, an "'arguable deficiency in opinion-writing technique is not a sufficient reason for setting aside an administrative finding where . . . the deficiency probably had no practical effect on the outcome of the case.'" Id. (quoting Benskin v. Bowen, 836 F.2d 878, 883 (8th Cir. 1987)). The undersigned agrees with the defendant that the ALJ's credibility determination was adequate.

Furthermore, the ALJ may discredit subjective complaints because of inconsistencies in the evidence as a whole. See Kisling v. Chater, 105 F.3d 1255, 1257 (8th Cir. 1997). The ALJ stated the inconsistencies on which he relied in discrediting plaintiff's testimony regarding his subjective complaints, and because his credibility finding is supported by substantial evidence on the record as a whole, his credibility finding should be affirmed.

Plaintiff argues that the ALJ did not properly consider the opinions of either Dr. Palen or Dr. Varma. This argument is without merit. Dr. Palen's report is dated July 12, 1994, (Tr. 160-61), more than one and one-half years before plaintiff's

alleged onset date. Dr. Palen's opinion in July 1994 was not relevant to the time period before the ALJ.

Plaintiff argues that the ALJ should have obtained more specific medical opinions. The ALJ is required to order consultative medical examinations and tests, when the other medical evidence is insufficient for determining whether the claimant is disabled. See Barrett v. Shalala, 38 F.3d 1019, 1023 (8th Cir. 1994); 20 C.F.R. §§ 404.1519a(b) and 416.919a(b) (2001).

Plaintiff argues that the ALJ's residual functional capacity finding was vague and incomplete. Residual functional capacity is what an individual is capable of doing despite his limitations. See 20 C.F.R. §§ 404.1545, 416.945 (2001). The ALJ was required to determine plaintiff's residual functional capacity based on all the relevant evidence. See Anderson v. Shalala, 51 F.3d 777, 779 (8th Cir. 1995); 20 C.F.R. §§ 404.1546, 416.946 (2001). Based on the evidence he found credible, the ALJ found that plaintiff could occasionally lift ten pounds, use his hands for manipulation or handling, and sit for six hours in an eight hour day. Thus, he could perform the full range of 'sedentary' work. 20 C.F.R. §§ 404.1567 and 416.967. The ALJ also found that plaintiff had no significant non-exertional impairment which limited the work he can perform. (Tr. 16).

The ALJ also concluded that plaintiff could not perform his past relevant work, but could perform other work existing in significant numbers in the national economy. The ALJ applied the Medical Vocational Guidelines at 20 C.F.R. Part 404, Appendix 1, Subpart P, Rules 201.21 and 201.28, which directed a conclusion that plaintiff was not disabled. (Tr. 16).

Plaintiff asserts that the ALJ's RFC finding is insufficient because he did not specifically treat each of the exertional capacities set out in Social Security Ruling 96-8p, because he did not include a narrative discussion for each conclusion, and because he did not consider Dr. Palen's opinion. As discussed previously, the ALJ was not required to consider Dr. Palen's opinion in

formulating his RFC finding, because that opinion did not relate to the relevant time period.

Further, the ALJ's findings conform with the definition of "sedentary work" in the regulations, that sedentary work

> involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties.

20 C.F.R. §§ 404.1567(a), 416.967(a) (2001). The record supports the ALJ's findings. In December 1996, plaintiff reported to Dr. Carter that his activities included a three mile walk and jog. (Tr. 165). Plaintiff was able to complete two thallium stress tests in 1996 which required him to exercise on a treadmill. (Tr. 200, 240). In June 1996, Dr. Munch completed a form to assist plaintiff with re-licensing as an EMT, indicating she believed he was capable of performing the physical demands of that job. (Tr. 189). And plaintiff himself testified that he could walk up to a half mile. (Tr. 340, 342).

RECOMMENDATION

For these reasons, it is the recommendation of the undersigned that the decision of the defendant Commissioner of Social Security denying benefits to plaintiff be affirmed. The action should be dismissed with prejudice.

The parties are advised they have until September 17, 2002, to file written objections. The failure to file timely, written objections may waive the right to appeal issues of fact.

DAVID D. NOCE
UNITED STATES MAGISTRATE JUDGE

Signed this _____ day of September, 2002.

Plaintiff had a fair hearing and full administrative consideration in accordance with applicable statutes and regulations. Substantial evidence on the record supports the Commissioner's decision that plaintiff was not "disabled" within the meaning of the Social Security Act. Consequently, plaintiff was not entitled to disability benefits. Accordingly, the Commissioner's decision should be affirmed.

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ARGUMENT I

The decision of the Commissioner is not supported by substantial evidence in that the residual functional capacity (hereinafter "RFC") established by the Administrative Law Judge (hereinafter "ALJ") is vague and incomplete and the ALJ does not specify the evidence which supports the RFC as required by Social Security Ruling 96-8p. Thus at Step 5 of the sequential evaluation process the Commissioner failed to meet his burden in establishing an RFC which supports a finding that plaintiff can perform other work existing in significant numbers in the national economy.

RFC is what a claimant can still do despite his limitations. The Commissioner is directed to consider a claimant's ability to meet certain demands of jobs, such as physical demands, mental demands, sensory requirements and other functions. RFC is an assessment based upon all the relevant evidence. 20 C.F.R. § 404.1545(a). Ordinarily, an RFC is an assessment of an individual's ability to do sustained work-related physical and mental activities in a work setting on a regular and continuing basis. A "regular and continuing basis" means eight hours a day, for five days a week, or equivalent work schedule. Social Security Ruling 96-8p.

The RFC assessment must first identify the individual's functional limitations or restrictions and assess his or her work-related abilities on a function by function basis. Only after that may an RFC be expressed in terms of the exertional levels of work, sedentary, light, medium, heavy, and very heavy. RFC is not the least an individual can do despite his or her limitations or restrictions, but the most. Social Security Ruling 96-8p. In disability determinations at Step 4 and 5 of the sequential evaluation process set forth in 20 C.F.R. §§ 404.1520 and 416.920, in which the individual's ability to do past relevant work and other work must be considered, the adjudicator must assess RFC. It is imperative upon the adjudicator to consider all allegations of physical and mental limitations or restrictions and make every

reasonable effort to assure that the file contains sufficient evidence to assess RFC. Social Security Ruling 96-8p.

The RFC assessment must address both the remaining exertional and non-exertional capacities of the individual. Exertional capacity addresses an individual's limitations and restrictions of physical strength and defines the individuals remaining abilities to perform each of seven strength demands: sitting, standing, walking, lifting, carrying, pushing, and pulling. Each function must be considered separately even if the final assessment will combine activities. Social Security Ruling 96-8p. In regards to non-exertional capacity, the adjudicator must consider all work-related limitations and restrictions that do not depend on an individual's physical strength, i.e., all physical limitations and restrictions that are not reflected in the seven strength demands, and mental limitations and restrictions. Non-exertional capacity assesses an individual's ability to perform physical activities such as postural (e.g., stooping, climbing), manipulative (e.g., reaching, handling), visual (seeing), communicative (hearing, speaking), and mental (e.g., understanding and remembering instructions and responding appropriately to supervision). As with the exertional capacity, non-exertional capacity must be expressed in terms of work-related function. Social Security 96-8p.

The RFC assessment must include a narrative discussion describing how the evidence supports each conclusion, citing specific medical facts (e.g., laboratory findings) and nonmedical evidence (e.g., daily activities, observation). In assessing RFC, the adjudicator must discuss the individual's ability to perform sustained work activities in an ordinary work setting on a regular and continuing basis (i.e., eight hours a day, for five days a week, or equivalent work schedule) and describe the maximum amount of each work day related activity an individual can perform based on the evidence available in the case record. Social Security Ruling 96-8p.

The full range of sedentary work requires that an individual be able to stand and walk for a total of approximately two hours during an eight-hour work day. Social Security Ruling 96-9p. In order to perform a range of sedentary work, an individual must be able to remain in a seated position for approximately six hours of an eight-hour work day, with a morning break, a lunch period, and an afternoon break at approximately two hour intervals. Social Security Ruling 96-9p. An ability to stoop occasionally (i.e., from very little up to one-third of the time) is required in most unskilled sedentary occupations. A complete inability to stoop would significantly erode the unskilled sedentary occupational base and any finding that the individual is disabled would apply. Social Security Ruling 96-9p.

Mental activities that are generally required by competitive, remunerative, unskilled work consist of understanding, remembering, and carrying out simple instructions; making judgments that are commensurate with the functions of unskilled work (i.e., simple

work-related decisions); responding appropriately to supervision, co-workers, and usual work situations; and dealing with changes in routine work setting. Social Security Ruling 96-8p.

In the present case, the ALJ establishes the plaintiff's RFC as follows: "The Claimant retains the Residual Functional Capacity to lift and carry up to 10 pounds occasionally, to use his upper extremities to manipulate and handle objects and to sit 6 hours in an 8 hour day." (Tr. 17). The ALJ further finds that the plaintiff has "no significant non-exertional limitations which narrow the range of work he is capable of performing." The ALJ finds that plaintiff cannot return to his past work of pallet maker and laborer at Step 4. (Tr. 17). Finally, the ALJ uses the medical-vocational guidelines and finds that based on an exertional capacity for sedentary work along with the plaintiff's age, educational background and work experience, the Social Security Regulations direct a conclusion of "not disabled." (Tr. 18).

Plaintiff submits that the ALJ's RFC assessment failed to address the exertional capacities as required by Social Security Ruling 96-8p. Specifically, the ALJ's RFC fails to contain the plaintiff's maximum standing, walking, pushing, and pulling abilities, and the RFC does not contain the non-exertional capacities for physical activities such as postural (e.g., stooping, climbing, etc.) and the manipulative ability of reaching, as required by Social Security Ruling 96-8p.

In addition, plaintiff contends that the ALJ's RFC assessment fails to include a narrative discussion describing how the evidence supports each conclusion, citing the specific medical facts and non-medical evidence relied upon, as required by Social Security Ruling 96-8p. The plaintiff contends that had the ALJ taken into consideration Dr. Palen's opinion concerning plaintiff's left upper extremity, as set out in his report at Tr. 160-61, he may have found that plaintiff was not capable of lifting and carrying up to ten pounds occasionally and using both upper extremities to manipulate and handle objects. There is no way to know from a reading of the ALJ's decision whether he even considered the opinions of Dr. Palen.

The ALJ failed to discuss an exam performed by James E. Palen, M.D., which was performed on July 7, 1994. Dr. Palen's conclusion was that plaintiff suffered from chronic tendinitis of the left elbow, and Dr. Palen gave plaintiff a 30 percent partial disability rating of the left upper extremity. (Tr. 160-61). In addition, while the ALJ did discuss parts of the findings of consultative examiner D.K. Varma, M.D., at Tr. 12-13, the ALJ fails to mention that Dr. Varma's impression after an extensive examination of plaintiff was one of difuse musculoskeletal pain involving both upper extremities, both knees and both hips and lower back, cause undetermined. (Tr. 172). In addition, the ALJ failed to discuss the evidence which leads him to a conclusion that the plaintiff can lift and carry up to ten pounds occasionally, to use his upper

extremities to manipulate and handle objects and to sit six hours in an eight-hour day.

It is interesting to note that in this case no doctor has rendered an opinion regarding the seven strength demands which the ALJ must assess as required by Social Security Ruling 96-8p. Dr. Varma was the only doctor who examined plaintiff at the request of the Social Security Administration. Dr. Varma does not state what the plaintiff's strength limitations are, but he does state that plaintiff's work-related activities could not be evaluated without an EKG and chest X-ray. Despite this recommendation, the Social Security Administration failed to send plaintiff for a chest X-ray or EKG. In addition, none of plaintiff's treating doctors were asked by the Social Security Administration to render an opinion concerning the seven strength demands. At the very least, the ALJ should have developed the record by seeking more specific medical opinions, as the ALJ is permitted to do by 20 C.F.R. § 404.1527(c)(3). Essentially, the RFC which the ALJ did establish is arbitrary in that there is no medical evidence to support the limitations noted by the ALJ.

Without the establishment of an RFC which sets forth all of the exertional and non-exertional capacities of the plaintiff, the RFC is improper and cannot be used as a basis to make a finding that plaintiff is not disabled under the medical-vocational guidelines. As a result, the Commissioner failed to meet his burden at Step 5 of the sequential evaluation process in establishing plaintiff can perform other work existing in significant numbers in the national economy. Thus, the decision of the Commissioner must be reversed and remanded to the Commissioner for an award of benefits.

ARGUMENT II

The ALJ committed reversible error by failing to consider the subjective limitations of the plaintiff and finding the testimony of plaintiff is not fully credible without applying the proper credibility factors. In discounting the credibility of the plaintiff's subjective complaints, the ALJ specifically did not apply the factors mandated by Polaski v Heckler, 739 F.2d 1320 (8th Cir. 1984), and Social Security Ruling 96-7p. Social Security Ruling 96-7p which essentially incorporates the holding of the Polaski case is very specific about what is expected from an ALJ in making determinations of credibility. This Ruling reads, in relevant part, as follows:

> Because symptoms, such as pain, sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone the adjudicator must consider the individual statements of symptoms with the rest of the relevant evidence in the case records in reaching a conclusion about the credibility of the individual's statements. In determining the credibility of the individual statements, the adjudicator must

> consider the entire case record, including the objective medical evidence, the individual's own statements about symptoms, statements and other information provided by treating or examining physicians or psychologists and other persons about the symptoms and how they effect the individual, and any other relevant evidence in the case record. An individual's statements about the intensity and ability to work may not be disregarded solely because they are not substantiated by objective medical evidence.

Social Security Ruling 96-7p.

The text of the Polaski decision itself lists other specific factors for the ALJ to consider in his credibility assessment, including a credibility related discussion of the plaintiff's work experience; the frequency and intensity of pain suffered by the plaintiff; precipitating and aggravating factors for said pain; the testimony of others regarding the observable limitations in the plaintiff's ability to function, and the type, dosage, and side effects of the medications taken by the plaintiff. Polaski, 739 F.2d at 1322.

Before undertaking a critique of the ALJ's analysis, it is important to keep several points in mind. While an ALJ is given deference in determining issues of credibility, he is not given "unfettered discretion" to dismiss or disregard the subjective complaints of pain by a claimant. He must provide some explicit and sound basis for his decision to discount the plaintiff's testimony. Morse v. Shalala, 16 F.3d 865 (8th Cir. 1994). The Polaski case and cited regulations provide a very specific framework for the analysis to be used. The ALJ's judgments in pursuing that analysis are subject to the review of the court, both as to the application of the facts and the law. Indeed the scope of the court's view is a "scrutinizing analysis" of the full record. Wilcutts, 143 F.3d at 1136, and cases cited therein.

In the present case, in assessing the plaintiff's credibility, the ALJ does, on the surface, undertake a Polaski-style credibility analysis, even citing the case. While the ALJ does cite certain credibility factors, a careful review of the record reveals that his analysis is incomplete, deeply flawed, and not supported by the substantial evidence of the record.

The ALJ cites the following regarding the statements concerning plaintiff's impairments:

1. Claimant drives around town, but his arms and legs go to sleep. (Tr. 14).
2. The plaintiff testified that he can walk fine but cannot run or jump. (Tr. 14).
3. The plaintiff testified that he has dizziness since 1992 and the medication he takes makes it worse. (Tr. 14-15).
4. The plaintiff testified that he has episodes of dizziness twice a day that last 15-20 minutes. (Tr. 15).

5. The plaintiff testified that he avoids driving and is disoriented by dizzy spells. (Tr. 15).
6. The plaintiff testified that he has pain in his left elbow when he straightens it. (Tr. 15).
7. The plaintiff testified that he could not lift over 10 pounds, he could walk one-half mile and he is limited by his heart condition more than his knee. The plaintiff testified that he could stand 20 minutes and could sit 20 to 30 minutes before his legs went to sleep. The plaintiff testified he had no strength in his hands but could lift and carry a four-pound sack of flour or sugar or a gallon of milk by switching hands. (Tr. 15).
8. The plaintiff testified that he avoids steps because of his knee and heart. (Tr. 15).
9. The plaintiff testified that he still goes to the shooting range once a month. He last went hunting in 1997. (Tr. 15).
10. The plaintiff testified that his medication does help ease his pain so he can tolerate it, but it makes him drowsy. (Tr. 15).
11. The plaintiff testified that his vision is blurred and he can no longer read with his bifocals. (Tr. 15).

In discussing the plaintiff's subjective complaints, the ALJ finds that there is nothing in the objective medical records to support his allegations that he has no strength in his hands and no objective support for his allegations of numbness in his extremities. The ALJ states that plaintiff's visual acuity was 20/20 in both eyes when tested. The ALJ further notes that plaintiff was able to walk and jog three miles a day in December 1996 without chest pain. The ALJ notes that plaintiff was able to go deer hunting in November 1996 and 1997 and reported no difficulties. The ALJ states that plaintiff was able to go to the shooting range twice a week according to his report in December 1996 and only once a month by his testimony. The ALJ found this evidence to demonstrate plaintiff's ability to use the upper extremities to handle objects and to lift and hold the weight of a firearm and absorb the shock of discharging a weapon, while also demonstrating a certain visual acuity assuming the plaintiff can see the targets. (Tr. 15).

The ALJ, however, fails to discuss the majority of the Polaski factors. Specifically, the ALJ failed to discuss the plaintiff's work experience. The plaintiff's earnings comp determination form reveals that plaintiff had earnings from 1985 to 1992 which ranged from $3,470.45 to a maximum of $28,898.25. (Tr. 61). The earnings comp determination form also revealed that plaintiff would receive an individual disability benefit of $792.60 and a family maximum benefit of $1,188.90. (Tr. 63). The record reveals that plaintiff has had above average earnings which, it appears, were not considered by the ALJ in his credibility assessment.

The ALJ recited plaintiff's testimony that he has pain in his left elbow when he straightens it. The ALJ does not specifically discount this complaint, but the ALJ, as previously mentioned in Argument I, fails to discuss the medical report of Dr. Palen which indicates that plaintiff suffers chronic tendinitis in his left elbow and has a 30 percent permanent partial disability rating of his left upper extremity. Dr. Palen's opinion seems to support this subjective complaint of plaintiff. The ALJ notes that plaintiff complained of dizziness; however, the ALJ failed to mention the objective medical evidence which contradicts plaintiff's complaint. One could assume the ALJ found that complaint to be credible. The ALJ notes that plaintiff testified the medication he takes makes his dizziness worse and that the medication makes him drowsy. The ALJ cites no objective medical evidence which contradicts this testimony. Thus, one could assume the ALJ must have found this subjective testimony credible though, the ALJ makes no mention of the side effects of the medication in the RFC. The ALJ devotes a part of his credibility analysis to plaintiff's hunting abilities. The plaintiff submits that the ALJ mischaracterizes the actual testimony of the plaintiff concerning his hunting and the time he spends at the shooting range. The actual testimony of plaintiff is different than that cited by the ALJ in his decision. Specifically, the plaintiff testified at Tr. 351 as follows:

> Q. How much do you go to the shooting range?
>
> A. Well, my son has traded for a shotgun the other night and he wanted to go and shoot it. And we went the other night. We probably go about once every month. I used to get a lot of relief just by going out there. But I don't like going. Turkey season is coming up. I don't feel like going. I don't know if I can take the recall of my gun or not.
>
> Q. Okay, when is the last time you went hunting?
>
> A. Deer hunting. That was in October, November. Didn't shoot a shot. Didn't see a deer. Well I saw a deer on the first day, but I didn't shoot it. I just don't feel like doing it. Turkey season's coming up here you know. Everybody goes out and listens and tries to figure out where the gobblers are. I don't feel like going and listening. I can't get up in the morning.

The ALJ concludes that plaintiff has the ability to use the upper extremities to handle objects and lift and hold the weight of a firearm and absorb the shock of discharging a weapon when in fact

none of the plaintiff's testimony even comes close to saying that the plaintiff actually has held a firearm and discharged it.

The ALJ failed to specifically set forth the daily activities testified to by the plaintiff and otherwise found in the record. The plaintiff testified he does not do any yard work or cleaning around the house. (Tr. 344-45). The plaintiff testified that he could run a vacuum cleaner and change the sheets on his good days, but on his bad days he could not. (Tr. 345). These daily activities were not discussed by the ALJ.

In this case, the ALJ did not properly apply the credibility factors. The ALJ reached conclusions regarding plaintiff's credibility which demonstrate a result-based determination of not disabled that is contrary to the appropriate procedure under the regulations of the Commissioner and Eighth Circuit case law. If not reversed outright on other grounds, this case should be reversed and remanded to the Commissioner for a proper determination of plaintiff's credibility.

REQUEST FOR RELIEF

WHEREFORE, plaintiff prays that the Court reverse this decision and remand to the Commissioner for an award of benefits or, in the alternative, to reverse and remand it to the Commissioner for further proceedings consistent with Eighth Circuit law; to award plaintiff reasonable attorney's fees under the Equal Access to Justice Act; and for any further relief this court deems just.

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In this case, the ALJ expressly found that plaintiff does not suffer from an impairment that precludes all types of work activity. The ALJ discredited plaintiff's allegations of disabling pain. In doing this, he considered the record as a whole, including the objective medical evidence, his lack of treatment and medication,[2] his daily activities,[3] and his lack of work restrictions.[4] (Tr. 21). He found that plaintiff could perform the full range of sedentary work. (Id.)

The undersigned believes that the case must be reversed and remanded to the Commissioner for further consideration of the August 4, 1999, MRI report that indicated a herniated disc.

> The regulations provide that the Appeals Council must evaluate the entire record, including any and material evidence that relates to the period before the date of the ALJ's decision. See 20 C.F.R. § 404.970(b). The newly submitted evidence thus becomes part of the "administrative record," even though the evidence was not originally included in the ALJ's record. . . . If the Appeals Council finds that the ALJ's actions, findings, or conclusions are contrary to the weight of the evidence, including the new evidence, it will review the case. See 20 C.F.R. § 404.970(b). [If the Appeals Council finds that the subject evidence does not call for review of the ALJ's decision, the reviewing court does] not evaluate the Appeals Council's decision to deny review, but rather we determine whether the record as a whole, including the new evidence, supports the ALJ's determination.

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[2]The ALJ found that plaintiff did not seek treatment for his leg and knee problem until July 1998, six months following his quitting work for this reason. (Tr. 20).

[3]The ALJ did not specify what evidence of activities he relied on or what the activities were. (Tr. 21). Clearly, the ALJ's rendition of plaintiff's testimony in this regard does not support his finding of lack of credibility. (Tr. 18).

[4]The ALJ's reliance on this factor is undermined by the fact that, when plaintiff was examined by the medical sources, he was no longer working.

Cunningham, 222 F.3d at 500.

> In practice, this requires this court to decide how the ALJ would have weighed the new evidence had it existed at the initial hearing.

Bergmann v. Apfel, 207 F.3d 1065, 1068 (8th Cir. 2000). Even in this context, the court may not reverse the ALJ's decision "merely because substantial evidence may allow for a contrary decision." Id.

To qualify as "new" evidence, the report must not be just cumulative of evidence already in the record. Id. Here, the new MRI report indicated a herniated disc, which was not indicated by earlier MRI reports. Therefore, this is new evidence.

To qualify as "material" evidence, it must describe plaintiff's condition during the period of time up to the time the ALJ rendered his decision. 20 C.F.R. § 404.970(b). As set out above, the negative MRI report of the C6-7 level was for an imaging on November 25, 1998. (Tr. 176). The hearing before the ALJ was on April 22, 1999, and the opinion was issued on May 24, 1999. The positive MRI report of C6-7 was for an imaging on August 4, 1999. The issue presented is when did the herniation occur? If before May 24, 1999, the court must consider whether this report is such that it renders the ALJ's decision unsupported by substantial evidence. If after that date, then the report may be important evidence for a new application for benefits.

Clearly, if plaintiff had a herniated disc before the date of the ALJ's decision, such a report would demean currency of the prior MRI reports and perhaps support a determination of a disability onset date later than alleged by plaintiff. In any event, the August 1999 MRI report would provide a substantial basis for plaintiff's subjective complaints of pain. As set out above, if plaintiff suffers from a non-exertional impairment, such as pain, the Medical-Vocational Guidelines cannot be used to decide whether or not plaintiff is disabled and the current decision of the ALJ

would not be supported by substantial evidence on the record as a whole.

The date of the herniation (and perhaps a disability onset date) indicated by the August 4, 1999, MRI report is an issue that must be decided by the Commissioner and not by the court. Bergmann, 207 F.3d at 1071. For this reason, the decision of the Commissioner denying benefits must be reversed and the action remanded for further proceedings.

RECOMMENDATION

For the reasons set forth above, it is the recommendation of the undersigned that the decision of the Commissioner of Social Security be reversed under Sentence 4 of 42 U.S.C. § 405(g) and the action remanded to the Commissioner for further proceedings described above.

The parties shall have until September 16, 2002, in which to file written objections to this Report and Recommendation. The failure to file timely written objections may waive the right to appeal issues of fact.

DAVID D. NOCE
UNITED STATES MAGISTRATE JUDGE

Signed this _____ day of September, 2002.